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Original Paper

The Cultural Formulation Interview: Results from the international field trial in the Netherlands

Hans Rohlof, Rob C.J. van Dijk, Simon P.N. Groen, Neil K. Aggarwal, Roberto Lewis-Fernández

Abstract. *The American Psychiatric Association's DSM-5 Cross-Cultural Issues Subgroup developed the Cultural Formulation Interview (CFI) for routine use in the clinical assessment of any patient. The CFI has been tested in an international field trial in five countries. The aim of this study is to determine whether the CFI was perceived as feasible, acceptable, and clinically useful for patients (n=30) and clinicians (n=11) in the Netherlands. The study was conducted as part of an international field trial in five countries. Earlier studies have revealed that the ethnic diversity of the psychiatric population in the Netherlands may cause communication problems in mental health and reduce the accuracy of psychiatric diagnoses. Semi-structured interviews have been developed in the Netherlands to identify cultural issues in diagnostic assessment. In the Netherlands, 11 clinicians were trained in a structured program to administer the CFI. They conducted 30 interviews among patients of foreign and Dutch origin. The clinicians and patients used quantitative and qualitative questionnaires before and after the administration of the CFI. Patients as well as clinicians were positive about the feasibility, acceptability, and perceived utility of the CFI. Patients were slightly more positive than clinicians about its clinical utility. The CFI did not lead to diagnostic changes, possibly due to the characteristics of the mental health institutes. The CFI is a feasible, acceptable, and potentially clinically useful instrument in psychiatric practice. Its value may be greatest for patients among whom communication and diagnostic problems are expected.*

Keywords: Cultural formulation interview, cultural interview, DSM-5, cultural competence, the Netherlands.

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INTRODUCTION

In the Netherlands, the proportion of migrants (defined as having one or both parents born in another country) in the population has increased since the 1980s. This number is expected to increase further from 22.6% in 2017 to 31.1% in 2060 (Stoeldraijer & Garssen, 2011). The largest group of migrants is

J.G.B.M. Rohlof, MD. Psychiatrist-researcher, Centrum '45, Oegstgeest (until 2015), and Utrecht University, the Netherlands. Since 2015 attached to Transparant Mental Health, Leiden.
Rob C.J. van Dijk, Medical anthropologist, advisor on diversity management to Parnassia Academy, Parnassia Psychiatric Institute, The Hague, the Netherlands.
Simon P.N. Groen, Cultural anthropologist, De Evenaar, Center for Transcultural Psychiatry North-Netherlands, GGZ Drenthe, Beilen, the Netherlands, and researcher, Amsterdam Institute for Social Science Research, University of Amsterdam, Amsterdam, the Netherlands.
Neil K. Aggarwal, Assistant professor of clinical psychiatry, Columbia University and research psychiatrist, New York State Psychiatric Institute, New York, NY, USA
Roberto Lewis-Fernández, Professor of clinical psychiatry, Columbia University, and director, New York State Center of Excellence for Cultural Competence, New York State Psychiatric Institute, New York, NY, USA

Correspondence to: J.G.B.M. Rohlof, MD. Mailing address: van Oldenbarneveltstraat 38, 2334 AH Leiden, the Netherlands.
E-mail: info@rohlof.nl

non-Western, numbering almost 2.2 million out of a population of 17 million (CBS, 2017). The largest non-Western groups are from Turkey (400,000), Morocco (391,000), Surinam (341,0000), and the Netherlands Antilles (153,000). Migrants from Syria are a fast-growing group, increasing from 22,000 in 2015 to 72,000 in 2017. In the major cities such as Amsterdam and Rotterdam, almost half of the population is not of Dutch origin. Soon, the original Dutch population will be the largest minority group in these cities, one of dozens of other groups.

There has also been a substantial increase in the number of migrants who use mental health services. In Rotterdam, the second largest city of the country, the number of migrant patients in mental health care increased significantly between 1990 and 2004 (Dieperink et al., 2007). Before, accessibility and utilization of mental health services were major problems, but currently the provision of culturally sensitive and effective, high-quality care is the key issue. In order to achieve this goal a thorough understanding of the patient and adequate communication in mental health care are crucial. Without these, treatment participation is difficult to achieve, as has been found in studies on depression (Blom et al., 2010; Fassaert et al., 2010). Clinicians' lack of understanding and inadequate communication could also lead to earlier treatment discontinuation and more missed appointments (Korrelboom et al., 2007).

Moreover, high-quality mental health care for migrants depends on an accurate diagnostic process. A common opinion in psychiatry is that psychiatric disorders share many characteristics all over the world, but that the expression of these disorders may vary in different cultures (see discussion in Kleinman, 2008). As a consequence, research has revealed difficulties in the diagnostic process across cultural population groups (Zandi et al., 2007; Lu, 2004). These difficulties are related to the diversity of collective understandings individuals have of themselves and their sociocultural environment, and to their views and expectations about mental health, including illness explanations, symptom presentations, and help-seeking behaviours. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) acknowledges the influence of culture on mental health: it states, "all forms of distress are locally shaped, including DSM disorders" (American Psychiatric Association, 2013: p. 758). Transcultural psychiatrists and medical anthropologists agree that greater attention should be paid to the impact of culture and other contextual factors in the assessment of psychiatric disorders. They claim that clinicians should be aware of disparities in locally shaped cultural notions between themselves and their patients, the individual interpretations of collective concepts and behaviour patterns that patients hold, as well as the cultural relativity or embeddedness of mental health concepts, methods, and interventions. Ignoring these claims may lead the clinician to neglect the individual's cultural experiences (Lakes et al., 2006). Neglecting these experiences may lead to an oversimplification in the clinical encounter. According to Arthur Kleinman (2005) the first commandment in clinical practice is: "Do no harm by stereotyping."

Historical background: Outline for Cultural Formulation of Diagnosis

In the 1980s and 1990s, the claim of the Diagnostic and Statistical Manual-III (1980) and III-R (1987) to be a classification system that was valid worldwide was criticized. A study group of the United States' National Institute of Mental Health consisting of psychiatrists and anthropologists proposed a number of adjustments (Lewis-Fernández, 1996; Mezzich et al., 1999). As a result, the Outline for Cultural Formulation (OCF) was introduced in DSM-IV (American Psychiatric Association, 1994). In DSM-5, the OCF is described as a framework clinicians use during a clinical evaluation to assess how culture influences the illness process, the social context, and the clinical history of the illness. In the Netherlands, the OCF was introduced with clinical vignettes and theoretical explanations (Borra et al., 2002).

Cultural interview

The DSM-IV OCF did not include a standardized method to guide clinicians on how to develop questions to gather information from patients to construct an OCF, or how to implement the OCF in clinical practice (Lewis-Fernández, 2009). In the Netherlands, the Cultural Interview (CI) was

developed as a tool to help clinicians construct an individual OCF (Rohlof et al., 2002). The CI is a semi-structured questionnaire with 40 questions that allows the user to obtain information on the cultural background of the patient and its influence on the individual's psychopathology. A less time-consuming version has been developed which has been tested in a comparative study. This version (Brief Cultural Interview, BCI) has been shown to be better understood and appreciated by patients than the original CI and yields results that are comparable (Groen et al., 2017).
Over time, specific versions were introduced for specific domains and groups, including forensic psychiatry, child psychiatry, patients with schizophrenia, patients with intellectual disability, and general practitioners. These versions and their utilization possibilities are extensively described in a Dutch publication (Van Dijk et al, 2012), and are available online (www.cultureelinterview.nl). According to clinicians, the CI contributes to the quality of the therapeutic relationship (Piksen, 2010). A small-scale research project showed that the use of the CI in interpersonal therapy with patients from developing countries reduced treatment discontinuation while retaining treatment efficacy (Gumbs, 2012).

Cultural Formulation Interview
During the development of DSM-5, the Cross-Cultural Subgroup of the Study Group on Gender and Culture Issues reviewed existing operationalisations of the OCF worldwide and created the Cultural Formulation Interview (CFI). This Cross-Cultural Issues Subgroup consisted mainly of North American transcultural psychiatrists, but also of experts from Great Britain, Sweden, and the Netherlands (including the first author).
Part of this process involved a literature review on the use of the OCF. Its conclusion was that the OCF was being used in education and, to a lesser extent, in clinical practice, but that evaluative and efficacy studies were largely lacking (Lewis-Fernández et al, 2014; Rohlof et al, 2017).

Similar to the Dutch CI, the CFI is an operationalization of the OCF as a semi-structured interview. The CFI provides topics and guidelines for assessing the impact of a patient's cultural background and context on mental health problems and can be regarded as an invitation to patients to share their health-related views with their clinician. The thread of the interview is the patient's story about his or her illness experience and its meaning, as understood by the patient and his or her community. The CFI is constructed following four core themes of the OCF (American Psychiatric Publishing, 2013:749):

1 Cultural definition of the problem (questions 1-3);
2 Cultural perceptions of cause, context and support (questions 4-10);
3 Cultural factors affecting self-coping and past help seeking (questions 11-13)
4 Cultural factors affecting current help seeking (questions 14-16).

The CFI has patient and informant versions, which obtain the same information from the patient directly or from an accompanying person.
In addition twelve supplementary modules may be used to obtain in-depth information during the initial assessment or later in therapy (see table 1). All of these components of the CFI are available online (www.psychiatry.org/dsm5).

The CFI is intended for use at the beginning of the initial evaluation, can be integrated in a standard assessment interview, and may be administered to all patients regardless of the clinical setting, culture or ethnicity.

Field trial
An international field trial was part of the CFI development process. A field trial version of the CFI consisting of 14 questions was tested in clinical sites in the United States, Canada, Peru, Kenya, India, and the Netherlands.
The overall results of the international trial consisted of interviews with 318 patients by 75 clinicians (Lewis-Fernández et al, 2017). The CFI was found to be feasible, acceptable, and useful. Clinician feasibility ratings were significantly lower than clinician acceptability and utility ratings and also than patient ratings. Acceptability and utility ratings were not significant different between clinicians and

patients. In the case clinicians performed more than one interview, their feasibility ratings improved significantly, and the subsequent interviews required less time.

Table 1 Cultural Formulation Interview and the supplementary modules

Cultural Formulation Interview	
14 questions (field trial version), 16 questions (definitive version)	
Supplementary modules	
Name of the module	**Number of questions**
Explanatory model	14
Level of functioning	8
Social network	15
Psychosocial stressors	7
Spirituality, religion and moral traditions	16
Cultural identity	34
Coping and help-seeking	13
Patient-clinician relationship	5 + 7 [1])
School-age children and adolescents	20 + 8 [2])
Older adults	17
Immigrants and refugees	18
Caregivers	14

[1]) : 5 questions to the patient, 7 questions the clinician has to ask to himself.

[2]) : 20 questions to the child, 8 issues for the parents.

Site-specific results of the field trial from Pune, India were reported from 36 patients and 8 clinicians (Paralikar et al, 2015). Their study results showed no significant difference between clinicians, patients, and their relatives in the evaluation of the CFI. The presence of serious mental disorders was associated with lower overall ratings among patients. Overall value of the CFI (a composite score of feasibility, acceptability, and utility) was lower for patients and clinicians when relatives were present. Clinicians experienced in treating culturally diverse patients rated the CFI more positively than less experienced clinicians.

In the Netherlands, three institutes took part in the trial: Centrum ’45 (Oegstgeest), a national centre of expertise offering clinical treatment of patients with complex posttraumatic stress disorders including

traumatized refugees; De Evenaar Centre for Transcultural Psychiatry North Netherlands, part of GGZ Drenthe Mental Health Care (Beilen), offering clinical treatment to refugees, asylum seekers, and migrants; and PsyQ Depression Ambulant, part of the Parnassia Psychiatric Institute (the Hague), offering outpatient treatment of depression to an ethnically diverse patient population. The first three authors were responsible for the field trial in the Netherlands.

The research questions were the following:
- Is the CFI feasible in clinical practice?
- Is the CFI acceptable for patients and clinicians?
- Is the CFI potentially useful in clinical practice?

In this article, data from the Dutch site of the international field trial are presented. First the methodology is described, followed by the quantitative and qualitative data. That will enable us to answer the three research questions. In the discussion we will compare our findings to those of the overall international field trial and to the Indian site, and compare the CFI with the CI. We will end by noting some limitations.

METHODS

As in all sites, the Dutch clinicians followed a strict protocol to enable comparison to the other field trial sites. The Dutch researchers recruited clinicians from their institutes. After being introduced to the field trial, clinicians attended a 2-hour training session consisting of:

(1) review of CFI written guidelines,
(2) a 24-minute video of a CFI simulation between a patient and a clinician,
(3) interactive behavioural simulations pairing clinicians to practice the CFI through sample cases created by the authors or based on their own clinical experience,
(4) coaching and feedback by local principal investigators who led the training session,
(5) a final period for questions and answers.

The training video featured a clinician and an actor from the United Kingdom playing the roles of clinician and patient. Data on clinician perceptions of the field trial training have been published elsewhere (Aggarwal et al., 2016).

The CFI assessment was conducted in English or in the local language(s) at each site of the trial. The Dutch researchers translated the CFI into Dutch, following the method of three translations independent of one another; these three versions were discussed by the translators, resulting in one consensus translation. Clinicians were asked to administer the CFI in Dutch or English at the beginning of the assessment phase of a newly admitted patient. They were instructed to follow the sequence and exact wording of the CFI questions and to refrain from responding to the patients' answers with new questions that took the interview beyond the scope of the CFI. They could ask the patient to explain details, but not probe any further.

All sites were provided with a standard set of debriefing questionnaires for patients and clinicians [1,2]. These questionnaires were composed of closed questions that were answered using a four-point Likert scale, and of open-ended questions [3]. The researchers translated the patient questionnaires into Dutch. The questionnaires for clinicians were not translated, since all the selected Dutch clinicians were fluent in English.

Patients were recruited between January and April, 2012. The referral coordinator or the research assistant reviewed the inclusion/exclusion criteria for each patient referred. Patients were enrolled sequentially as recruited. All patients who came for a first assessment with one of the participating clinicians were included. These were new patients not seen before by institute clinicians. Exclusion criteria were insufficient fluency in Dutch or English, intellectual disability, and poor reality testing (florid psychosis). One of the aims of the Dutch field trial was to include a representation of the patient

population at each institute. Therefore, all ethnic groups were included, patients from foreign and Dutch origin. Patients were referred for enrolment in the study if they suffered from depressive disorder or posttraumatic stress disorder.
Before the assessment phase started, all patients received an explanation of the trial, were asked for permission to participate and, after agreeing, provided written informed consent. Patients were told that refusal to participate would not have any influence on their treatment. After completion of the socio-demographic questionnaires, participating patients completed the debriefing questionnaires.

Clinicians filled in information about their own demographic and cultural background, education, and experience with culturally diverse patients. They also completed the debriefing questionnaires after each CFI and a separate questionnaire after the first and the third CFI. All CFIs were audiotaped to register their duration and to examine clinicians' administration of the CFI, including sequence and proper use of the questions. Other parts of the assessment, such as the general psychiatric assessment, were not audiotaped. Quantitative and qualitative data were analyzed separately from the data collected at the other international field trial sites. Audiotaped interviews were checked for consistency and compliance with the CFI questions.

Ethical approval
Before the field trial, ethical approval was verified by the medical ethical committee of GGZ Drenthe Mental Health Care. Because of the non-invasive character of the study, it was decided that no approval was required, in accordance with the Medical Research with Human Subjects Act (Dutch: WMO).

RESULTS

At the Dutch field trial site, the CFI was administered by 11 clinicians who interviewed 30 patients; each of the three institutes contributed 10 patients. In practice, patients were only excluded because of poor Dutch or English fluency. All patients who were asked to participate in the trial agreed; there were no refusals. There were 21 male patients and 9 females in the age range of 21-77 years (median 41.2 years). Of these, 13 patients were Dutch natives, and 17 were migrants (first and second generation), originating from 12 countries: 3 from Surinam, 2 each from Morocco, Turkey, and Sierra Leone, and 1 each from Afghanistan, Azerbaijan, Bosnia, Burundi, Guinea, Ingushetia, Iraq, and Rwanda . They were referred for outpatient (n=10) or day-clinical or inpatient treatment (n=20), before the CFI-enhanced interview.
The eleven clinicians were psychiatrists (n=2), psychologists or psychotherapists (n=6) and social psychiatric nurses (n=3). Three of them had more than 50 hours of cultural training, 3 had fewer than 10 hours, and these data were missing for 5 clinicians. Six were males and 5 were females; 7 were natives and 4 migrants. Two clinicians administered the CFI with 1 patient, one with 2 patients, 6 with 3 patients, and two with 4 patients.
Patients' and Clinicians' characteristics are shown in table 2.

Table 2 Patients and clinicians characteristics of the Dutch CFI field trial

Patients (n=30)	
Age, mean (SD)	41.87 (15.33)
Years of education, mean (SD)	12.08 (4.97)
Female, *n* (%)	9 (30.00)
Foreign-born	17 (56.57)
New to CFI clinic, *n* (%)	20 (66.67)
Axis 1 diagnoses, n (%)	
0	1 (3.33)
1	12 (40.00)
2	9 (30.00)
3 or more	8 (26.67)
Clinicians (n=11)	
Age, mean (SD)	43.64 (11.46)
Years providing healthcare, mean (SD)	15.55 (12.64)
Female, *n* (%)	5 (45.45)
Professional discipline, n (%)	
Psychiatrist/ psychiatry trainee	2 (18.18)
Psychologist	6 (54.55)
Social worker	3 (27.27)
Other mental health clinician	0 (0)
Foreign-born, n (%)	2 (18.18)
Frequency of contact with patients of different cultures, n (%)	
Daily	10 (90.91)
Weekly or monthly	1 (9.09)
Seldom or never	0 (0)
Hours of cultural training	
< 10 h	3 (50.00)[1]
10-50 h	0 (0)
>50 h	3 (50.00)

[1] : Data unavailable for five participants

Range of the CFI duration was 8 to 40 minutes (mean 18.8 minutes, SD=8.8). The CFI plus the general psychiatric assessment had a total mean duration of 87.5 minutes (SD=28.7). From the audiotapes it was clear that clinicians generally adhered to the CFI instructions, although some asked additional questions. Table 3 shows the mean clinician and patient evaluation scores on the feasibility, acceptability, and perceived clinical utility of the CFI. Like the method used in the international field trial, we assigned positive values for agreement (+1 for agree and +2 for strongly agree) and negative values for disagreement (−1 for disagree and −2 for strongly disagree).

Table 3 Mean evaluation by clinicians and patients in the Netherlands of the feasibility, acceptability, and perceived clinical utility of the field trial version of the CFI

	Clinicians (*n*=11) Mean (SD)	Patients (*n* = 30) Mean (SD)
Feasibility	1.0 (0.6)	0.9 (0.4)
Acceptability	1.0 (0.4)	1.0 (0.4)
Perceived Clinical Utility	0.9 (0.3)	1.1 (0.4)

Scale -2 till +2

Clinicians were positive about the three implementation-relevant aspects of the CFI. However, clinicians seemed less certain than patients about the CFI's utility; the clinician overall mean utility score (0.9) was slightly lower than the patients' score (1.1). Some specific utility items showed low scores among clinicians. For instance, clinicians were not entirely sure that the CFI increases their confidence in the diagnosis (mean= 0.00, SD= 0.86 on a scale from -2 to +2) or that it contributes to treatment planning (mean=0.21, SD=0.98). They were more satisfied about the general utility of the CFI, for instance in terms of facilitating rapport with the patient (mean=0.62, SD=0.72). Clinicians were generally satisfied with respect to feasibility and acceptability. Accumulating experience with the CFI did not lead to more satisfaction among clinicians. Only 1 out of 11 clinicians scored less than 0.5 on acceptability, only 2 out of 11 scored less than 0.5 on clinical utility, and no clinician scored less than 0.5 on feasibility.

Participating patients were generally positive about the CFI, similar to the clinicians' scores. Patients scored high on certain feasibility items such as how easy the CFI questions were to understand (mean=1.00, SD=0.65), duration of the CFI (mean=0.52, SD=0.99), and the flow of the interview (mean=0.93, SD=0.94). Patients were also satisfied with the acceptability and potential utility of the CFI. Out of thirty patients, six were less satisfied about the feasibility, three were less satisfied about acceptability, and two were less satisfied about clinical utility than clinicians.

In sum, patients and clinicians in the Netherlands provide similar evaluations of the feasibility and acceptability of the CFI, but patients score slightly higher on utility.

Findings from the debriefing interviews with the research assistants were that that patients' Dutch fluency was sometimes overestimated, that patients sometimes had difficulty completing Likert scales, and that they often required clarification such as on the evaluation categories and questions. Difficulties administering the CFI were related to some patients' limited Dutch fluency, given the exclusion of a professional interpreter from the trial so as to limit the cultural information obtained from sources other than the CFI.

Responses to the open-ended debriefing questions revealed that the CFI afforded clinicians a better understanding of the patient's context. However, clinicians did not comment on changes to the diagnosis brought about by the CFI. Some clinicians felt constrained by what they perceived as the strict guidelines of the interview protocol, the wording and sequence of the questions, and the instruction not to depart

from the field trial instruction to pursue the patient's answers, expressed emotion, and non-verbal reactions.

Due to the small groups of patients from the different countries it was not possible to perform further analysis of the data. A comparison between native Dutch and migrants was judged to have little validity, since the group of migrants came from very different countries, and three of them were also second-generation migrants. This would have made the analysis very tentative.

CONCLUSIONS AND DISCUSSION

Patients and clinicians in the Netherlands found the CFI to be feasible, acceptable, and clinically useful; overall scores were similar in both groups, with the exception of clinical utility, which was slightly lower among clinicians than patients.

Compared to the Pune, India site of the international study (Paralikar et al., 2015), both patients and clinicians in the Netherlands evaluated the CFI as slightly less valuable. Compared to the international field trial (Lewis-Fernández et al, 2017), participating clinicians in the Netherlands were more positive about the feasibility of the CFI, but had scored similarly on acceptability and clinical utility. By contrast, participating patients in the Netherlands reported lower ratings than in the full field trial: 0.9 versus 1.33 on feasibility, 1.0 versus 1.27 on acceptability, and 1.1 versus 1.26 on clinical utility. These are substantial differences, which might be due to the larger number of migrants in the Dutch study: 56% of the Dutch sample was foreign-born, compared to 35% of the overall sample. One possibility is that migrants may have faced language difficulties participating in the interviews.

In the Dutch field trial, clinicians did not report finding the CFI useful in clarifying the patient's diagnosis on open-ended questions. This may be due to the restriction of the disorders in the policy of the three Dutch institutes. Only patients with presumed depressive disorder or posttraumatic stress disorder were allowed. Additionally, the high professional standard in the institutes may have had a ceiling effect with respect to the diagnostic process.

Clinicians were the oldest group of the international field trial, with the most years providing mental healthcare. Patients' characteristics were comparable to the mean of the international field trial. There was a significant difference between patients from developed counties and from developing countries in being born outside the country: in the developing counties this was almost non-existent. These factors may also have influenced the difference between the results in the Netherlands compared to the results of the complete field trial.

The DSM-5 CFI international field trial led to several changes in the CFI: the number of questions was increased from 14 to 16 and questions (or parts thereof) that were not well understood were reformulated. The DSM-5 guidelines still include the instruction to formulate questions as proposed and in the order listed. Incorporating the CFI questions in a naturally progressing conversation is recommended. The questions now are introduced as examples, which can be reformulated depending on the situation. Furthermore, additional and probing questions are allowed.

In the DSM-5, the CFI is considered specifically useful in certain cases, such as when:

- There are considerable cultural, religious or socio-economic differences between the clinician and the patient which can make diagnostics more difficult;
- The clinician is uncertain of the relationship between symptoms and diagnostic categories;
- There are problems with regard to assessing the gravity of the illness or the level of impairment;
- There are problems with engaging the patient in the treatment.

It is important to note that only the core CFI was part of the field trial. The supplementary modules were not included for logistical reasons despite being considered an integral part of the CFI. Further research is needed on when and how to use the supplementary modules. Moreover, additional work is required to assess whether the core CFI obtained enough information to construct an overall cultural assessment for diagnosis and care of a particular patient; this was not a goal of this study. This field trial assessed the field trial version of the CFI. Follow-up research in clinical practice is needed that focuses on the final DSM-5 version of the CFI including the supplementary modules.

The field trial did not compare the usefulness of the CFI with the CI in clinical practice. A comparative study would be needed. The CFI has the practical advantage of being shorter, so that it is easier to implement in a regular assessment interview than the CI. By contrast, it is unclear whether the CFI yields enough cultural and contextual information, in comparison to the CI. The CI tackles most of the relevant themes of the OCF, but takes longer than the CFI. For example, the CI contains more questions about the cultural identity of the patient, which can be relevant for medication treatment or psychotherapy. Additional questions on cultural identity are included in the CFI supplementary module on this topic, but this additional module may not be accessed by busy clinicians. In general, it is unclear whether any of the additional CFI supplementary modules will be used by most clinicians because of time pressure and workload.

One solution is to choose the cultural assessment instrument depending on the circumstances. For example, the CI could be used selectively, while the CFI can be used prior to every initial assessment, due to its short duration. The existing CI and the new CFI are both an operationalization of the OCF. They address individual experiences and contexts of clinical problems. They share the same focus on narrative, idiographic description, and themes. Both interviews are thus not completely interchangeable. In assessing patients from different cultures, the clinician's attitude and the treatment negotiation efforts are important, not only the diagnostic process. These require culturally sensitive and competent clinicians, methods, guidelines, protocols, and organisational structures (Kirmayer, 2012). Attention to the cultural aspects of mental health care also calls for reflection on the clinician's own clinical reality or medical culture, and therefore demands a culturally critical attitude.

LIMITATIONS

The results of the study should be interpreted with some caution.

First, the participating clinicians, mental health institutions, and patients were not representative of the Dutch mental health system. For instance, patients not fluent in Dutch or English were excluded.

Second, the CFI was not translated using back-and-forward translation methods, as is usually recommended.

Third, not all relevant clinician-related variables were included in the field trial. Although all participating clinicians were experienced professionals, their cultural competence was not fully assessed prior to the use of the CFI. Only 6 out of 11 clinicians revealed their cultural training: 3 had many hours of training, 3 had few. The clinician's level of cultural competence could have influenced their evaluation of the CFI.

Fourth, research conditions proved not to be optimal. Some patients were not acquainted with the general use of research instruments or had difficulty understanding the questions or completing Likert scales. Some patients were included despite some limited fluency in Dutch or English, which only became evident during the scoring of the questionnaires. However, this limited fluency did not affect the final data, since the research clinicians were able to clarify every item in the instruments.

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NOTES

1. Clinicians used the following questionnaires:
   - Clinician demographic form
   - Patient referral form
   - Debriefing instrument for clinicians after every encounter

- Debriefing instrument for clinicians after first and third encounter
- Open-ended questions for debriefing clinicians

Patients used the following questionnaires:

- Patient demographic form
- Debriefing instrument for patients
- Open-ended questions for debriefing patients

2. Examples of questions to the patient (closed)
   These questions helped me to explain what kind of help I would like to have (clinical utility)
   These questions were easy to answer (feasibility).
   These questions should be asked by every clinician (acceptability)
3. Options: strongly disagree (-2), disagree (-1), agree (1), strongly agree (2)

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